

COMAR 10.09.15

MARYLAND MEDICAL ASSISTANCE PROGRAM

PODIATRY SERVICES PROVIDER MANUAL

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DEFINITIONS

1. **"Ambulatory surgical center"** means any distinct, Medicare-certified entity that operates exclusively for the purpose of providing surgical services to patients not requiring hospitalization.
2. **"Emergency services"** means treatment for traumatic injury or infection other than athlete's foot or chronic mycotic infection of the nail bed.
3. **"Personal hygiene care"** means routine hygienic care in the absence of pathology.
4. **"Podiatrist"** means a Doctor of Podiatry (D.P.M.) who is licensed to practice podiatry by the State Board of Podiatric Medical Examiners or by the state in which the service is rendered.
5. **"Practice podiatry"** means:
 - (a) To diagnose or surgically, medically or mechanically treat any ailment of the human foot or ankle, any ailment of the anatomical structures that attach to the human foot, or the soft tissue below the mid-calf; and
 - (b) Does not include:
 - (i) Surgical treatment of acute ankle fracture; or
 - (ii) Administration of an anesthetic, other than a local anesthetic.
6. **"Routine podiatric care"** means the cutting or removal of corns and calluses, and the trimming, cutting, clipping or debriding of toenails.

PROVIDER REQUIREMENTS

The provider must meet all license requirements as set forth in COMAR 10.09.36.02 (General Medical Assistance Provider Participation Criteria) and all conditions for participation in the Program as set forth in COMAR 10.09.36.03, including:

1. Be licensed and legally authorized to practice podiatry in the state in which the service is provided.
2. Ensure that all Clinical Laboratory Improvement Amendments (CLIA) certification exists for all clinical laboratory services performed, and

(a) If located in Maryland, comply with the requirements of Health-General Article, Title 17, Subtitles 2 and 3, Annotated Code of Maryland and COMAR 10.10.06, or

(b) If located out-of-state, comply with other applicable standards by the state or locality in which the service is provided.

3. Ensure that all X-ray or other radiological equipment is inspected and meets the standards established by COMAR 10.14.03 or other applicable standards established by the state or locality in which the service is provided.

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4. Not knowingly employ another podiatrist to provide services to Medical Assistance patients after that podiatrist has been disqualified from the Program.

COVERED SERVICES

The Medical Assistance Program covers the following podiatry services:

1. Medically necessary services, other than routine care, when these services are:

(a) Rendered to a recipient in the podiatrist's office, the recipient's home, a hospital, a nursing facility, a free-standing clinic or elsewhere,

(b) Performed by the podiatrist or another licensed podiatrist in the podiatrist's employ,

(c) Clearly related to the recipient's individual medical needs as diagnostic, curative, palliative or rehabilitative, and

(d) Adequately described in the patient's medical record.

2. Office, home, nursing facility or domiciliary visits for routine podiatric care for recipients who are diabetic or who have a vascular disease affecting the lower extremities.

3. Drugs dispensed by the podiatrist in an emergency or drugs which cannot be self-administered within the limitations of COMAR 10.09.03 (Pharmacy Services).

4. Injectable drugs administered by the podiatrist within the limitations of COMAR 10.09.03.

5. Drugs prescribed by the podiatrist within the limitations of COMAR 10.09.03.

6. Medical equipment and supplies prescribed by the podiatrist within the limitations of COMAR 10.09.12 (Disposable Medical Supplies and Durable Medical Equipment).

7. Emergency services and related follow-up care.

ROUTINE PODIATRIC CARE

Program reimbursement for routine foot care, the cutting or removal of corns and calluses and the trimming, cutting, clipping or debriding of toenails, is limited to **one visit every 60 days** for recipients who have diabetes or peripheral vascular diseases that affect the lower extremities, when rendered in the podiatrist's office, the recipient's home, a nursing facility or domiciliary. The appropriate ICD-9-CM code indicating that the patient has a condition relating to diabetes or peripheral vascular disease must be entered in **Block 21** of the CMS-1500 (Diagnosis or Nature of Illness or Injury) as the secondary diagnosis

and the podiatric diagnosis as primary.

The following CPT-4 Surgery codes are used to bill for routine care for those recipients who qualify: **11055-11057** and **11719**. These codes should be used when they are the only services provided. Routine care for those recipients who qualify may be billed separately when provided in conjunction with other medically necessary surgical procedures at the same visit. Routine foot care provided "incident to" a surgical procedure is considered part of the surgical procedure. No additional allowance will be made for such incidental care.

Evaluation and management services provided on the same day as routine foot care is considered ineligible for reimbursement, with the exception of the initial E&M service performed to diagnose the patient's condition. Evaluation and management services provided on the same day as routine foot care by the same doctor for the same condition are not eligible for payment except if it is the initial E&M service performed to diagnose the patient's condition or if the E&M service is a significant separately identifiable service.

The global surgery rules apply to routine foot care procedure codes 11055-11057 and 11719. An E&M service billed on the same day as a routine foot care service is not eligible for reimbursement unless the E&M service is a significant separately identifiable service documented by medical records.

PODIATRIC VISITS

The following CPT-4 Evaluation and Management codes are used to bill for podiatric visits which include the key components of an history, examination and medical decision making:

<u>OFFICE</u>	<u>HOME</u>	<u>NURSING FACILITY</u>	<u>DOMICILIARY</u>
99201-99204	99341	99304-99305, 99307	99324, 99334
99211-99214	99347		

Podiatric visit codes are not to be used if the only service rendered was routine care.

EMERGENCY SERVICES

"Emergency Services" means treatment for traumatic injury or infection other than athlete's foot or chronic mycotic infection of the nail bed. The procedure codes and fees for emergency services are the same as those for the podiatric visits. Payment is made under these codes only when payment is not being requested under one of the surgical

procedure codes. If a patient is treated in the office on an emergency basis but no surgical procedure is performed, the appropriate visit code should be billed; and, if a surgical procedure is performed, the code for that procedure should be used instead of the visit code. A podiatrist may include the charges for radiological and laboratory services performed by the podiatrist when used in the treatment of trauma or infection when billing for emergency services. Hospital

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emergency department services are not covered.

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INPATIENT SERVICES

The Podiatry Program does not cover non-surgical hospital visits. Payment will be made only for actual surgical procedures rendered to eligible recipients during the hospital stay. When it is necessary to perform a surgical procedure on an inpatient, Program reimbursement includes all subsequent hospital and office visits associated with the patient's after-care. The administration of local anesthesia for surgery is not covered as a separate charge, but is included in the fee for the surgical procedure.

SURGICAL PROCEDURES

If multiple procedures are performed at the same operative session, the 5-position CPT-4 procedure code must be followed by a 2-position modifier code for all procedures following the first procedure. The major procedure should be reported without a modifier. The modifier **-51** should be used for the second and subsequent procedures. The Program will pay up to the amount listed in the fee schedule for the procedure without the modifier and up to 50% of the amount in the fee schedule for the procedures with the -51 modifier.

When a procedure has a code for both a single procedure and for each additional procedure, use the modifier **-51** for the second and subsequent procedures. When only one procedure code is available, regardless of the number of procedures performed, use the same procedure code with the modifier **-51** to report the second and subsequent procedures, and report the additional procedures in **Block 24G** (Units of Service) of the CMS-1500.

When there is no procedure code to identify a bilateral procedure, report the code for the unilateral procedure on the first line, and again on a second line with the modifier **-51** to identify that the procedure was performed bilaterally.

AFTERCARE DAYS

Listed surgical procedures include the operation per se and normal, uncomplicated follow-up care. Fees for surgical procedures include follow-up care for the same number of days listed in the Medicare Fee Schedule. The Program does not pay the podiatrist for hospital and office visits during the surgical aftercare period. When the follow-up period is listed as "0", the listed value is for the surgical procedure only. All post-operative care in those cases is to be invoiced on a fee-for-service basis.

INJECTABLE DRUGS

The Program reimburses podiatrists for drugs injected in the office or home setting in accordance with the injectable drug codes (J-codes) under COMAR 10.09.02.07 (Physicians' Services). Podiatrists must bill their acquisition cost for injectable drugs. The actual cost must be the charge. The acquisition cost is defined as the purchase price of the drug, less any discounts, for the amount administered, including any portion of shipping and handling. The Program will reimburse the podiatrist at the lower of the podiatrist's actual cost or the Program's

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estimate of provider acquisition cost. The Program uses the Medicare Part B Drug Fee Schedule to estimate provider cost.

When an unlisted injectable drug is administered or the "strength" or amount administered is different from the J-code description, use the unlisted injectable drug code **J3490** in **Block 24D** of the CMS-1500, and write in the name of the drug, NDC number, and amount administered. The maximum units of service for an unlisted drug code is one. A copy of a current invoice which clearly shows the per unit cost of the drug must be attached to a claim whenever the unlisted injectable drug code J3490 is used. The calculation used to determine the acquisition cost must also be clearly written on the invoice.

SUPPLIES AND MATERIALS

Podiatrists must bill their acquisition cost for supplies and materials provided over and above those usually included in an office visit using procedure code **99070**. The acquisition cost is defined as the purchase price of the supply or material, less any discounts, for the amount provided, including any portion of shipping and handling. The name of the supply or material, the product catalog number and the amount given must be clearly written in **Block 24D** of the CMS-1500. A copy of a current invoice which clearly shows the per unit cost of the supply or material provided, including any portion of shipping and handling, must be attached to the claim form. The calculation used to determine the acquisition cost must also be clearly be written on the invoice.

POST-OPERATIVE SURGICAL REVIEW

Post-operative review of podiatric surgical procedures is conducted on a random basis by the Program to ensure that the Program's regulations are being followed by the provider. Pre- and post-operative x-rays may be requested as part of the review process.

NON-COVERED SERVICES

The Podiatry Program does not cover the following services:

1. Services not medically necessary,
2. Investigational or experimental drugs or procedures,
3. Services prohibited by the Maryland Podiatry Act or the State Board of Podiatric Medical Examiners,

4. Services denied by Medicare as not medically justified,
 5. Drugs and supplies which are acquired by the podiatrist at no cost,
 6. Injections and visits solely for the administration of injections, unless medical necessity and the patient's inability to take oral medications are documented in the patient's medical record,
 7. More than one visit per day unless adequately documented in the patient's medical record as an emergency,
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8. Visits by or to the podiatrist solely for the purpose of the following:
 - (a) Prescription or drug pick-up,
 - (b) Collection of specimens for laboratory procedures, except by venipuncture, capillary or arterial puncture, and
 - (c) Interpretation of laboratory tests or panels,
 9. Physical therapy when performed as a podiatric service,
 10. Orthotics and inlays of any type and related services,
 11. Disposable medical supplies,
 12. Administration of anesthesia as a separate charge,
 13. Corrective shoes,
 14. Braces,
 15. Personal hygiene care,
 16. Routine care, except for recipients who are diabetic or who have a vascular disease affecting the lower extremities,
 17. Non-surgical hospital visits,
 18. Laboratory or X-ray services not performed by the podiatrist or under the direct supervision of the podiatrist, and
 19. Podiatric inpatient hospital services rendered during an admission denied by the Program's utilization control agent or during a period that is in excess of the length of stay authorized by the utilization control agent.
 20. The podiatrist may not bill the Program nor the recipient for:
 - (a) Completion of forms and reports,
 - (b) Broken or missed appointments,
 - (c) Professional services rendered by mail or telephone,

(d) Services which are provided at no charge to the general public, and

(e) Providing a copy of a recipient's medical record when requested by another licensed provider on behalf of the recipient.

21. A licensed podiatrist shall perform in a licensed hospital or ambulatory surgical center, subject to the provisions of Health-General Article, §19-351, Annotated Code of Maryland, all osseous surgical procedures of the ankle, arthrodesis of two or more tarsal bones or a complete tarsal osteotomy. A licensed podiatrist who chooses to provide

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these services in an ambulatory surgical center must have current surgical privileges at a licensed hospital for the same procedures and must meet the requirements of the ambulatory surgical center.

BILLING TIME LIMITATIONS

Claims must be received within **12** months of the date that services were rendered. If a claim is received within the 12-month limit but rejected due to erroneous or missing data, re-submittal will be accepted within 60 days of rejection or within 12 months of the date that the service was rendered, whichever is later. If a claim is rejected because of late receipt, the recipient may not be billed for that claim.

Medicare/Medicaid Crossover claims must be received within **120** days of the date that payment was made by Medicare. This is the date of Medicare's Explanation of Benefits form. The Program recognizes the billing time limitations of Medicare and will not make payment when Medicare has rejected a claim due to late billing.

BY REPORT

When the fee for a surgical procedure is listed as by **REPORT** in the fee schedule, the value of the procedure is to be determined by medical review of a copy of the podiatrist's operative report or notes which must be submitted with the invoice. The report must contain the post-operative diagnosis and the main surgical procedure and supplementary procedure(s).

MAXIMUM REIMBURSEMENT

The reimbursement rates for podiatry services are the same as those for Physicians' Services established under COMAR 10.09.02.07. Podiatrists must bill their usual and customary charge to the general public. The Program will pay the lower of the podiatrist's usual and customary charge or the Program's fee schedule. Program reimbursement for procedures listed as by "Report" will be determined on an individual basis.

The fees listed in the Physicians' Services Provider Fee Manual represent the maximum fees allowed for specific procedures. Podiatrists must consider the fee paid by the Medical Assistance Program as payment in full and are prohibited by law from requesting or receiving additional payment from recipients or their families. If the Program denies payment or requests repayment on the basis that an otherwise covered service was not medically necessary, the podiatrist may not seek

payment for that service from the recipient or family members.

MEDICARE/MEDICAID CROSSOVERS

The Medical Assistance Program is always the payer of last resort. Whenever a Medical Assistance recipient is known to be enrolled in Medicare, Medicare must be billed first. Claims for Medicare/Medicaid recipients must be submitted on the CMS-1500 directly to the Medicare Intermediary.

When billing Medicare on the CMS-1500 form, check the Medicaid box
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in **Block 1.** of the CMS-1500, enter the recipient's 11-digit identification number in **Block 9a** and check "**Accept Assignment**" in **Block 27.** This will assure that Medicare will automatically forward the appropriate information to the Program which is responsible to pay for the deductible or coinsurance. Also make certain to check both **Medicare** and **Medicaid** in **Block 1** on the top of the CMS-1500 so as not to delay any payments due.

PODIATRY SERVICES REIMBURSEMENT

There is no separate fee schedule for podiatry services. Podiatrists are reimbursed according to COMAR 10.09.02.07, the current Physicians' Services Provider Fee Manual, which is also found on the DHMH website (www.dhmh.state.md.us) under Provider Information. This schedule lists all current CPT-4 codes in numeric order and the maximum non-facility and facility reimbursement. Podiatrists must have access to the latest revision of CPT-4 in order to properly complete the CMS-1500. The provider must select the procedure code that most accurately identifies the service performed. Any service rendered must be adequately documented in the medical record. The records must be retained for six years. Lack of acceptable documentation may cause the Program to deny payment, or if payment has already been made, to request repayment, or to impose sanctions, which may include withholding of payment or suspension or removal from the Program. Payment for services is based upon the procedure(s) selected by the provider. Although some providers delegate the task of assigning codes, the accuracy of the claim is solely the provider's responsibility and is subject to audit.

TELEPHONE DIRECTORY

Podiatry Services Policy/Coverage Issues	(410) 767-1722
Eligibility Verification System (EVS)	(866) 710-1447
Provider Master File (Enrollment) P.O. Box 17030 Baltimore, MD 21203	(410) 767-5340
Provider Relations P.O. Box 22811 Baltimore, MD 21203	(410) 767-5503 (800) 445-1159
Electronic Media Submittal	(410) 767-5863
Missing Payment Voucher/Lost or Stolen Check	(410) 767-5503
Third Party Liability/Other Insurance	(410) 767-1771
Recoveries	(410) 767-1783
Medicaid Training Liaison Unit	(410) 767-6024
Claims (CMS-1500) P.O. Box 1935 Baltimore, MD 21203	
Claims (Adjustments) P.O. Box 13045 Baltimore, MD 21298	(410) 767-5346
Toll Free Number for any of the (410) 767- exchanges above, Ask for the appropriate 4-digit extension	(877) 463-3464